Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 68767
Grand Rapids, MI 49516-8767

Member Reimbursement Form

Customer Service

Phones
800-662-6667
800-257-9980 (TTY users)

Hours
8 a.m. to 5:30 p.m.
Monday through Friday

Please check all that apply.
I paid out of pocket and am requesting reimbursement for:

☐ Pharmacy prescription
☐ Medical service

Please attach receipts from medical providers or pharmacies, along with copies of your cancelled check (front and back) or credit card receipt.

MEMBER INFORMATION

Patient Name			Date of Birth
Subscriber Name		Contract No.	
Address		City	State / Zip Code
Phone: Day – Evening –	PCP who wrote referral	PCP Number (if known)	

PROVIDER / BILLING INFORMATION

Provider Name		Provider Name	
Address		Address	
Phone		Phone	
Services		Services	
Date of Service ▶		Date of Service ▶	
Total Charges ▶ $	If Requesting Reimbursement, Total Paid ▶ $	Total Charges ▶ $	If Requesting Reimbursement, Total Paid ▶ $

NOTE: If you are reporting more than two services, add a separate sheet for each item and supply the necessary documentation.

ADDITIONAL INFORMATION: Complete any information that applies.

1. Was the above service rendered on an emergency basis? ☐ Yes ☐ No
2. Was your BCN primary care physician notified? ☐ Yes ☐ No – If No, explain below
3. Were you referred to the attending provider by your primary care physician? ☐ Yes ☐ No – If No, explain below

If applicable, please explain why services were not performed by a BCN participating provider.

Please explain the circumstances regarding your claim/reimbursement request.
(Attach additional sheets if necessary.)

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

Subscriber's Signature	Date